STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 87204-001**

v

USHL Health and Life Insurance Company
Respondent
_____/

Issued and entered
This 15th day of February 2008
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On January 15, 2008, XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq*. The Commissioner reviewed the information and accepted the request on January 22, 2008.

The Commissioner notified USHL Health and Life Insurance Company (USHL) of the external review and requested the information USHL used in making its adverse determination. USHL provided information on January 25, 2008.

The issue here can be decided by applying the terms of USHL's certificate of coverage (the certificate), the contract that defines the Petitioner's health care benefits. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner has health care coverage under a group policy. She had a medical emergency related to a yellow-jacket wasp sting on August 21, 2007 and was taken to XXXXX, the closest emergency/urgent care facility. XXXXX is an out-of-network provider.

Claims were submitted and USHL paid them at the out-of-network level of benefits. The Petitioner appealed. USHL reviewed the claim but upheld its decision and sent the Petitioner a final adverse determination dated January 9, 2008.

III
ISSUE

Is USHL required to pay more for the Petitioner's emergency services at XXXXX?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says that after being stung by a yellow-jacket wasp she experienced facial swelling and extreme breathing difficulty so her husband sought treatment for her at XXXXX. She says she was aware that XXXXX was an out-of-network facility. The area in-network facility does not have urgent care facilities. Upon arrival the Petitioner says she was immediately admitted and treated. The urgent care physician confirmed immediate treatment was essential and probably saved her life.

The Petitioner wants USHL to pay the entire charge for her emergency treatment because she says there was no in-network facilities with emergency services close enough to treat her when her life was at risk.

Respondent's Argument

USHL says that, under the Petitioner's plan, the benefit amounts payable are based on the network status of the providers. In-network and out-of-network benefits are different because of the

discounts USHL receives when an insured person receives treatment from a network provider. USHL pays for eligible expenses of a covered health service. For a network provider, the eligible expense is the same as the provider's discounted fee. However, if a provider is not in USHL's network, the provider may bill for the difference between the provider's charge and USHL's eligible expense amount. Page 11 of the Petitioner's certificate states:

> Network shall refer to those Physicians and facilities that have contracted to participate in the preferred provider organization chosen by the Company. In-Network shall refer to services rendered by Network providers. Out-of-Network shall refer to services rendered by non-participating providers.

USHL further says that the out-of-network benefit in the schedule of benefits for emergency/urgent care is 70% of eligible expenses after deductible.

USHL argues that the benefit amounts payable are not based on the reason why treatment was received from a non-network provider. USHL asserts that the emergency claims were processed correctly at the out-of-network benefit level and it is not responsible for any additional charges.

Commissioner's Review

The Petitioner wants XXXXX entire charge paid because her condition was life threatening and required emergency treatment at the closest emergency/urgent care facility.

It is unfortunate that the area network facilities did not provide emergency or urgent care services. However, the Commissioner's role in this case is limited to determining whether USHL correctly processed the Petitioner's claims under the terms and conditions of the certificate.

There is no dispute about the status of XXXXX – they are not in USHL's network. The Petitioner's certificate is clear: benefits are payable at the out-of-network level when services are not rendered by a Preferred Provider. USHL pays 70% of it's eligible expense for all emergency or urgent care services at out-of-network facilities. Nothing in the certificate requires USHL to pay the full charge when an out-of-network facility is used.

The Commissioner, while sympathetic to the Petitioner's arguments, nevertheless finds that USHL correctly processed the claims for XXXXX under the terms and conditions of the certificate.

V
ORDER

The Commissioner upholds USHL's adverse determination of January 9, 2008. USHL is not required to pay more for the Petitioner's August 21, 2007 emergency care.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.